Gynecological Aspects of Irritable Bowel Syndrome

By: P. J. Whorwell, BSc, MD, FRCP

Consultant Physician and Senior Lecturer in Medicine, University Hospital of South Manchester, Manchester, England

Some years ago we demonstrated that many patients with irritable bowel syndrome (IBS) suffer from a wide variety of symptoms which could not just be arising from the large bowel (colon). These symptoms are particularly important as not only do they cause a lot of misery but also because patients are often afraid to mention too many of these complaints for fear of being labeled as "neurotic" by their doctor. Lethargy (fatigue), backache, bladder and gynecological symptoms can be especially troublesome, sometimes leading to referral to the wrong specialist and, on occasions, inappropriate treatment. In this article, I am going to focus on the gynecological and bladder aspects of IBS.

In our first study we found that women with IBS tended to suffer more from painful periods, noticed that their IBS symptoms were worse at the time of their periods and frequently suffered with pain on intercourse. This led us to think that these women with IBS might commonly be referred to a gynecologist particularly if their abdominal pain was low down (pelvic pain). It also made us wonder how much the pain on intercourse might be affecting their lives.

Over 70% of patients attending our clinic said they experienced pain on intercourse frequently enough for it to affect their enjoyment of sex. The pain resembled their bowel pain and often came on some time after intercourse, sometimes as late as the next day. Fortunately, many patients had very understanding partners but in some cases the problem put a lot of strain on relationships. Partners became suspicious if sex was being avoided because of IBS especially as they could not understand how sex could possibly make a bowel problem worse. If a partner can be educated and made more tolerant about this aspect of IBS, which can be very persistent, it can at least reduce the stress on the patient who is already often having major problems coping with all the other aspects of their bowel problem.

Gynecological Discomfort

We have also conducted surveys on patients attending gynecological clinics to see what proportion of them have IBS. We found that over 50% of patients seeing a gynecologist for lower abdominal pain suffer from IBS. Furthermore, when such patients are seen by a gynecologist, the outcome is often very unsatisfactory as not only is a gynecological cause less likely to be found than in those without IBS but, not surprisingly, the patient seldom gets any better despite having a wide variety of investigations and treatments.

> *"Disorders of the bowel, the bladder and the pelvic organs can all produce remarkably similar symptoms . . ."*

These results probably help to explain why in special IBS clinics, such as ours, we see so many patients who have had extensive gynecological surgery and are still no better. This is particularly important as it has been shown that abdominal surgery can sometimes actually make the symptoms of IBS worse.

We must be very careful however not to blame IBS for everything, otherwise we will start missing gynecological problems. Pelvic inflammatory disease (PID) and endometriosis need to be considered in the younger patient and one must always remember the possibility of gynecological cancer in the older subject. Fortunately, these conditions are relatively easy to detect and should be looked for if there are reasonable grounds for suspecting their presence. However, if nothing is found, the temptation to treat with antibiotics for instance, in case there might be some PID, should be strongly resisted as antibiotics can make IBS worse. Even more importantly, a pelvic organ (uterus, tube, ovary) should never be removed just to see if it makes that patient better—it seldom does unless it is diseased.

There is a very strong case to be made for gynecologists and gastroenterologists to be working far closer together on patients with lower abdominal pain but (in the absence of collaboration) what can be done until this happens? Fortunately, we find there is a simple rule that at least gives some clue to the source of the problem. If the pain is associated with upper abdominal symptoms (e.g. nausea) or pain above the umbilicus (belly button) or an abnormal bowel habit, it is more likely to be due to IBS. If these other features are absent, IBS is far less likely to be the cause of the trouble.

The bladder symptoms that are most often encountered in patients with IBS are frequency in passing urine, urgency and sometimes a degree of incontinence. Obviously, just as with gynecological symptoms, other causes need to be excluded and treated when it is appropriate. Probably the most commonly encountered problem associated

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with these bladder symptoms is that they are mistakenly taken as indicating that the patient has recurrent cystitis. This is especially important if the patient is treated with antibiotics which, as already mentioned, can make the patient (with IBS) worse. Thus, care should be taken to only treat cystitis when it is proven on urine culture. Another difficultly that can arise is that if there is an element of vaginal prolapse it can be almost impossible to decide whether it is the prolapse or the IBS that is causing the symptoms. Obviously, if it turns out to be the latter then a prolapse repair operation is less likely to be successful.

Summary

Disorders of the bowel, the bladder and the pelvic organs can all produce remarkably similar symptoms and it is essential to establish the exact source of the trouble in any particular individual. If you are offered surgery for an apparent "gynecological" or "bladder" problem and you have symptoms suggestive of IBS, make sure you know why this approach is being advised and that you are aware of all the pros and cons. Remember, medication can be stopped, but surgery cannot be reversed.